STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. BUILDING _____ B. WING _____	C 06/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN MANOR OF PAINTSVILLE	1025 EUCLID AVENUE PAINTSVILLE, KY 41240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey (KY14899) was conducted on June 1-3, 2010. Deficient practice was identified with the highest scope and severity level being at "G," with an opportunity to correct.	F 000		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide services in accordance with the resident's plan of care for one (1) of three (3) sampled residents (resident #1). Resident #1's plan of care revealed the resident required the assistance of two (2) staff members for transfers. However, on May 11, 2010, one (1) staff member transferred resident #1 from the bed to the wheelchair. During the transfer, resident #1 fell and sustained bruising to the left side of the resident's face (refer to F323). The findings include: A review of resident #1's medical record revealed the resident was admitted to the facility on March 31, 2010, with diagnoses that included Closed Fractured Femur, Osteoarthritis, Hip Replacement, Bilateral Knee Replacements, Anemia, and Congestive Heart Failure. A review of resident #1's comprehensive plan of care revealed the facility identified the resident had a Self Care Deficit and was At Risk for Falls, due to	F 282		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah Fitzpatrick	Administrator	6/25/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	Continued From page 1	F 282		

impaired/poor decision-making with decreased safety awareness, generalized weakness, and unsteady gait. The plan of care instructed staff that resident #1 was weight bearing with assistance with all transfers.

A review of resident #1's "CNA Care Record" for March, April, and May 2010 revealed resident #1 required the assistance of two staff members and a gait belt to do a pivot transfer. A review of the "CNA Assignment Sheet" revealed resident #1 required the assistance of two staff members for transferring.

An interview conducted on June 3, 2010, at 7:58 a.m., with SRNA (State Registered Nursing Assistant) #1 revealed the SRNA was assigned to resident #1 on May 11, 2010. SRNA #1 stated the charge nurse gave her/him a copy of the "CNA Assignment Sheet" for resident #1's group that detailed the level of assistance resident #1 required, which was assistance of two staff members. SRNA #1 stated the SRNA had seen the therapist transfer resident #1 with one staff member and thought the SRNA would be able to complete the transfer independently or without additional staff assistance. According to SRNA #1, resident #1 sat down too soon, sitting on the wheelchair arm and falling forward onto the floor, hitting the resident's eyebrow.

A review of resident #1's nurse's notes dated May 11, 2010, at 10:15 a.m., revealed resident #1 was found lying on the floor on the resident's left side with the SRNA's hand under the resident's left side of face. The note stated resident #1 had a large bruise over the left eye. A nurse's note dated May 11, 2010, at 10:50 a.m., revealed resident #1 was transferred to the local hospital

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F 282	Continued From page 2 for evaluation. A nurse's note dated May 11, 2010, at 10:00 p.m., stated the resident had a hematoma above the left eye with discoloration going from the resident's forehead to nose from the recent fall. Observation of resident #1 on June 1, 2010, during initial tour from 12:40 p.m. until 2:30 p.m., revealed the resident had purple bruising under the left eye and under the left jaw bone, with fading bruising to the forehead and cheek area, 21 days after the fall. An interview conducted on June 1, 2010, at 2:35 p.m., with the Staff Development Coordinator (SDC) revealed SRNA #1 and all new SRNAs were instructed during orientation to utilize the "CNA Care Plan" book containing the "CNA Care Record" for each resident to know how to care for each resident. The SDC stated during orientation the SRNAs were also instructed to utilize the "CNA Assignment Sheet" given to the SRNAs daily for instructions on how to care for each resident. An interview conducted on June 1, 2010, at 5:40 p.m., with the DON revealed each resident's required functional level/level of assistance was documented on the "CNA Assignment Sheet." The DON stated each SRNA received a copy of the "CNA Assignment Sheet" every day for their particular assigned group of residents to ensure each SRNA knows how to care for each resident. The interview revealed all SRNAs were instructed during orientation on the importance of utilizing the "CNA Assignment Sheet" to know how to care for each resident. The DON stated the facility's investigation of resident #1's fall on May 11, 2010, found SRNA #1 had resident #1's "CNA	F 282		

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F 282	Continued From page 3 Assignment Sheet" on May 11, 2010. However, the SRNA failed to utilize the "CNA Assignment Sheet" and implement care as stated in resident #1's plan of care. A review of the facility's investigation of resident #1's fall on May 11, 2010, revealed SRNA #1 attempted to transfer resident #1 unassisted even though the resident's care plan and "CNA Assignment Sheet" stated for the resident to be transferred with the assistance of two staff members.	F 282		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure one (1) of three (3) sampled residents received adequate supervision to prevent accidents (resident #1). Resident #1 was assessed by the facility to require the assistance of two (2) staff members for transfers. However, on May 11, 2010, one (1) staff member transferred resident #1 independently without assistance. The resident fell and sustained a large hematoma to the left side of the resident's face (refer to F282). The findings include:	F 323		

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F 323	Continued From page 4 Observation of resident #1 conducted on June 1, 2010, during the initial tour from 12:40 p.m. until 2:30 p.m., revealed the resident clean, dry, and well groomed. The resident was observed to have purple bruising under the left eye and under the left jaw bone with fading bruising to the forehead and cheek area. The observation revealed Occupational Therapy attempting to get resident #1 to get out of bed to participate in therapy; however, the resident refused to get out of bed, even with much encouragement from the therapist. When resident #1 was asked about how the resident sustained the bruising the resident stated, "I don't know." When the resident was asked about how staff transferred the resident the resident did not answer. A review of resident #1's medical record revealed the resident was admitted to the facility on March 31, 2010, with diagnoses that included Closed Fractured Femur, Osteoarthritis, Hip Replacement, Bilateral Knee Replacements, Anemia, and Congestive Heart Failure. A review of the resident's admission comprehensive MDS (Minimum Data Set) assessment dated April 28, 2010, revealed resident #1 required extensive assistance of two or more persons for transfers and ambulation. According to the Fall and ADL (Activities of Daily Living) RAPS (Resident Assessment Protocol Summary) dated April 28, 2010, resident #1 had decreased awareness of needs/limitation, generalized weakness especially to the lower extremities, with decreased balance/coordination. A review of resident #1's comprehensive plan of care revealed the facility identified the resident had a Self Care Deficit and was at risk for Falls,	F 323		

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F 323	Continued From page 5 due to impaired/poor decision-making with decreased safety awareness, generalized weakness, and unsteady gait. The plan of care instructed staff that resident #1 was weight bearing with assistance with all transfers. A review of resident #1's "CNA Care Record" for March, April, and May 2010 revealed resident #1 required the assistance of two staff members and a gait belt to do a pivot transfer. A review of the "CNA Assignment Sheet" revealed resident #1 required the assistance of two staff members for transferring. An interview conducted on June 3, 2010, at 7:58 a.m., with SRNA (State Registered Nursing Assistant) #1 revealed the SRNA was assigned to resident #1 on May 11, 2010. SRNA #1 stated the charge nurse gave her/him a copy of the "CNA Assignment Sheet" for resident #1's group that detailed the level of assistance resident #1 required, which was assistance of two staff members. The interview revealed Therapy usually transferred resident #1 to the wheelchair and that SRNA #1 did not usually get the resident out of bed. SRNA #1 stated the SRNA had seen the therapist transfer resident #1 with one staff member and thought the SRNA would be able to transfer the resident independently. The interview revealed the SRNA placed the resident's walker in front of the resident and the SRNA was instructing the resident to continue turning. According to SRNA #1, resident #1 sat down too soon, sitting on the wheelchair arm, which pitched the resident forward and caused the resident to fall on the floor face first, hitting the resident's left eyebrow. A review of resident #1's nurse's notes dated May	F 323		

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F 323	Continued From page 6 11, 2010, at 10:15 a.m., revealed resident #1 was found lying on the floor on the resident's left side with the SRNA's hand under the resident's left side of face. The note stated resident #1 had a large bruise over the left eye. A nurse's note dated May 11, 2010, at 10:50 a.m., revealed resident #1 was transferred to the local hospital for evaluation. A nurse's note dated May 11, 2010, at 3:30 p.m., revealed the resident returned to the facility with no new orders noted. A nurse's note date May 11, 2010, at 10:00 p.m., stated the resident had a hematoma above the left eye with discoloration going from the resident's forehead to nose from the recent fall. Observation of resident #1 on June 1, 2010, revealed the resident had purple bruising under the left eye and under the left jaw bone with fading bruising to the forehead and cheek area 21 days after the fall. An interview conducted on June 1, 2010, at 5:40 p.m., with the DON revealed upon admission each resident receives a "fall risk assessment" and screening by Therapy. The DON stated Nursing also assesses the resident and all this information assists with determining the resident's functional level and level of assistance required for the resident. The interview revealed the resident's functional level/level of assistance then was documented on the "CNA Assignment Sheet." The DON reported each SRNA receives a copy of the "CNA Assignment Sheet" every day for their particular assigned group of residents. An interview conducted on June 2, 2010, at 9:15 a.m., with LPN #1 revealed each resident was assessed upon admission concerning the resident's functional status and assistance required for each ADL. LPN #1 stated the	F 323		

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F 323	Continued From page 7 resident's functional status information was documented on the resident's "CNA Care Record" kept in the "CNA Care Plan" book and also documented on the "CNA Assignment Sheets." The interview revealed the "CNA Care Record" was updated and reprinted monthly and the "CNA Assignment Sheets" were updated and recopied every other day. The LPN stated each SRNA receives a "CNA Assignment Sheet" every day for their particular group of residents. A review of the facility's investigation of resident #1's fall on May 11, 2010, revealed SRNA #1 attempted to transfer resident #1 unassisted when the resident's care plan and "CNA Assignment Sheet" stated for the resident to be transferred with the assistance of two staff members. The investigation revealed resident #1 fell during the transfer on May 11, 2010.	F 323		

Mountain Manor of Paintsville does not believe and does not admit that any deficiencies existed, either, before, during or after the survey. Mountain Manor of Paintsville reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is it meant to establish any standard of care, contract obligation or position, and Mountain Manor reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance, or self-critical examination privileges which Mountain Manor of Paintsville does not waive, and reserves the right to assert in any administrative, civil, criminal claim, action or proceeding. Mountain Manor of Paintsville offers its responses, credible allegation of compliance, and plan of correction as part of its ongoing effort to provide quality care to its residents.

F 282

483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

It is the policy of Mountain Manor of Paintsville that the services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

1. The SRNA responsible for not following the plan of care for Resident #1 was initially given a disciplinary warning. After further review she was dismissed.

   The plan of care for resident #1 was reviewed for accuracy. The resident was care planned appropriately at the time of the investigation.

   On May 26, 2010 Mary Arms, DON began inservicing licensed staff and SRNAs regarding following the care plan of Resident #1 with special emphasis on safety related to transfers.

   All licensed nurses and SRNAs responsible for the care of Resident # 1 will be inserviced on the care plan of Resident #1 with emphasis placed on safety related to transfers. Mary Arms, DON will complete these inservices.

2. All residents requiring assistance with transfers will be identified and their care records will be reviewed for accuracy by Linda Vanover, RN, 1st Floor Supervisor and by Kelly Wallen, RN 2nd Floor Supervisor.

All CNA Care Records for these residents will be reviewed and updated if necessary to ensure that the plan of care for transfers is accurate. This will be done by the Floor Supervisors (Linda Vanover and Kelly Wallen) and Anna Caldwell, RN, ADON.

All licensed nurses and SRNAs will be inserviced on following the specific plan of care for all residents. Special emphasis will be placed on safety related to transfers.

All licensed nurses and SRNAs will also be inserviced on following the individualized nursing care plans and not to provide care based on visual observations of other departments such as therapy. Mary Arms, RN, DON will provide this education.

3. The facility policies concerning lifts and transfers will be reviewed and revised accordingly by Deborah Fitzpatrick, RN, Administrator; Robyn Akers, MSW/CSW, Assistant Administrator; and Mary Arms, RN, DON.

   Resident CNA Care Records are currently reviewed quarterly with the MDS and will continue.

   Random audits of CNA Care Records will be performed quarterly to ensure they have been updated. Linda Vanover, RN, 1st Floor Supervisor and Kelly Wallen, RN, 2nd Floor Supervisor will perform the audits and results will be given to Mary Arms, RN, DON. Each supervisor will audit 5% or 6 Care Records per month beginning in July 2010. The first audits will be completed prior to July 18th, 2010.

   Random audits of SRNAs performing transfers will also take place. Beginning in June, the Staff Development Coordinator (SDC) will perform three (3) random audits per week for one month using the attached form. In July, the SDC will perform three random audits per month to ensure SRNAs are performing transfers according to the resident plan of care. Results of these audits will be given to Mary Arms, RN, DON.

4. All results of random audits involving the Care Records as well as the audits concerning SRNA transfers in practice will be submitted to the Quality Assurance Committee quarterly. Robyn Akers, MSW/CSW will review the results of said audits.

5. The corrective date of action is July 18, 2010.

F 323

483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISON/DEVICES

It is the policy of Mountain Manor of Paintsville that the facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

1. The SRNA responsible for not following the plan of care for Resident #1 was initially given a disciplinary warning. After further review she was dismissed.

   The plan of care for resident #1 was reviewed for accuracy. The resident was care planned appropriately at the time of the investigation.

   On May 26, 2010 Mary Arms, DON began inservicing licensed staff and SRNAs regarding following the care plan of Resident #1 with special emphasis on safety related to transfers.

   All licensed nurses and SRNAs responsible for the care of Resident # 1 will be inserviced on the care plan of Resident #1 with emphasis placed on safety related to transfers. Mary Arms, DON will complete these inservices.

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   All CNA Care Records for these residents will be reviewed and updated if necessary to ensure that the plan of care for transfers is accurate. This will be done by the Floor Supervisors (Linda Vanover and Kelly Wallen) and Anna Caldwell, RN, ADON.

   All licensed nurses and SRNAs will be inserviced on following the specific plan of care for all residents. Special emphasis will be placed on safety related to transfers.

   All licensed nurses and SRNAs will also be inserviced on following the individualized nursing care plans and not to provide care based on visual observations of other departments such as therapy. Mary Arms, RN, DON will provide this education.

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